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SIMPSON, LECTURES ON THE DISEASES OF WOMEN, 12 PAGES.			

## CLINICS.

### CLINICAL LECTURE.

*Diphtheria: its Symptoms and Treatment* By WILLIAM JENNER, M. D., Special Professor of Clinical Medicine, University College; Physician to University College Hospital; the Hospital for Sick Children, etc.<sup>1</sup> Delivered to the Medical Clinical Class at University College Hospital.

LECTURE I.—Description of *Diphtheria*; Pathological Appearances in *Diphtheria*; Varieties of *Diphtheria*. Mild, Inflammatory, Insidious, Nasal, Primary, Laryngeal, Asthenic; *Septicæmia* as a Consequence of *Diphtheria*; Duration of *Diphtheria*; *Emphysema* in *Diphtheria*.

GENTLEMEN: On the table are several pieces of "false membrane," coughed up

<sup>1</sup> "Thinking" the author says, "that even an imperfect and incomplete account of the present epidemic of diphtheria in London, by a practitioner who has seen most of its severer phases, would be acceptable to the profession, I deter-


by a young gentleman twenty-one years of age, while suffering from diphtheria; also

mined to publish my experience. The symptoms of diphtheria, during the present epidemic, agree in all essential particulars with those observed in past epidemics. Indeed my study of the histories of epidemic and other diseases, leads me to the conclusion that diseases preserve their essential characters and natures from age to age, while the opinions of the profession respecting them and their treatment change from year to year. This change seems to be sometimes the result of the personal sway of some influential teacher—sometimes the result of real advances in pathology and therapeutics.

"The Lectures are dogmatical in tone, because they were addressed to students; and I believe dogmatism to be essential for successful student-teaching. I endeavoured to make them practical in regard of diagnosis and treatment, because they were delivered to a clinical class. The details of the cases are few, partly because the majority of the patients were seen in private, and partly because I have found that students are more confused than instructed, when copious details of a case are placed before them.

"Since the Lectures were delivered, several other cases of diphtheria have come under my observation. Some of these having presented special points of interest, or peculiarities illustrating general statements in the Lectures, I have added materially to the text, and slightly modified its arrangement."

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the pharynx, larynx, and lymphatic glands connected with those parts, from two children who died a few days since from the same disease.

Diphtheria is one of the acute specific diseases; that is to say, it is a general disease, runs a quick and definite course, and has a specific cause. Its anatomical character is—spreading inflammation of the mucous membrane of the pharynx, attended by exudation of lymph.

About three years since, diphtheria became epidemic in London. Since the early part of 1858, I have seen about fifty-eight cases, of which thirty-four have proved fatal.<sup>1</sup> And these cases have, with few exceptions, been scattered over the district bounded on the south by Holborn and Oxford Street, on the north by the Highgate and Hampstead hills, on the east by Hackney, and on the west by Shepherd's Bush: they may be considered to represent the general characters of the epidemic in its severer forms in the north of London. As several of the cases occurred within the last three weeks, and as they differed in no essential particulars from some of the cases I saw three years ago, I conclude that the epidemic preserves its original characters.

As in the other acute specific diseases, so in diphtheria, the general or the local symptoms may predominate, and give its special feature to the case. The patient may die from the severity of the general disease, or he may die from the severity of some one of its local consequences. In this particular, diphtheria bears a closer affinity to typhoid fever than to any of the other acute specific diseases; for in typhoid fever, as you know, the patient may die of the general affection: *i. e.*, of the fever; or, the symptoms of the general disease being trifling in the extreme, he may die of a local consequence of the fever, *e. g.*, perforation of the bowel. Diphtheria is by no means new to England. I have seen cases of it every now and then, as long as I have practised medicine, and the writings of the older English physicians prove that, from time to time, it has been epidemic, or very common, in many parts of England. You

will understand, however, that I am to day describing diphtheria as it presented itself in the cases from which the preparations on the table and under the microscope were obtained, and from the other cases of the disease which I have seen during the past three years. I have told you that the anatomical character of diphtheria is spreading inflammation of the pharynx, attended by exudation of lymph. It may be that the mucous membrane covering one of the tonsils is the primary seat of the exudation, or it may be that the arches of the palate, the posterior surface of the soft palate, the uvula, the nares, or the mucous membrane of the pharynx itself is the starting-point of the local lesion. At first there is redness and some swelling of the parts, and perhaps a little excess of mucus on them; then a white or gray patch, due to the presence of a layer of lymph, is seen on the reddened surface. Usually the redness involves the whole mucous membrane within reach of the eye, posterior to, and inclusive of, the anterior arches of the palate, before any lymph is exuded. Sometimes you see at once many little points of lymph: sometimes only one. Thus starting from one or many centres, the exudation spreads anteriorly on to the soft palate, upwards to the posterior nares, and downwards to the upper surface of the epiglottis, and, if not arrested by nature or by art, it descends into the larynx, the trachea, and the bronchi. I have seen, though not during the present epidemic, the lymph extend into the cesophagus and stomach.

Tear off, during life, the lymph from the mucous membrane of the pharynx, and you expose a raw, bleeding surface, which in a few hours is covered by a new layer of lymph.

I have spoken of lymph, but included under the word lymph are a variety of very different looking substances. Sometimes the lymph has a granular appearance and very little consistence or tenacity; sometimes the part is covered with a thinner or thicker coating of a white or gray pulpy substance; so thin, soft, and separated from each other may be the little particles which together form the coating of lymph, that we cannot apply to it, correctly at least, the term membrane; for no shred of lymph can be stripped from the surface. At other times the layer of lymph is very tough, elastic, and as much as one eighth of an

<sup>1</sup> From these numbers it is not to be concluded that half the cases of diphtheria prove fatal, seeing that a very large proportion of the 58 cases came under my observation solely because of their extreme gravity, many of the patients being in a dying state.

inch in thickness. In the one case, the lymph resembles cream in appearance and consistence; in the other, it resembles wash-leather. Between the two extremes we meet with all intermediate conditions as regards consistence and tenacity.

Pus, granular corpuscles, oleo-protein granules, and epithelium, constitute the bulk of the softer forms of the so-called lymph; such fibres as we see in the buffy coat of blood coagula constitute the bulk of the toughest varieties of "lymph." Now and then, ulceration, and even sloughing, of a superficial layer of the subjacent mucous membrane occurs; and blood and pus, and semi detached pieces of lymph may form fetid shreds of some size.

As to the presence of vegetable growths in the diphtheritic exudation, no doubt they have occasionally been seen; but I am sure they have not been present in several cases I have carefully examined; consequently, I feel satisfied that epiphytes have played no essential or important part in the cases of diphtheria I have seen.

At the bedside, and in this room, I have seized every opportunity of impressing on you the general fact, that when a part is severely or deeply inflamed, the lymphatic glands to which the lymphatics of the inflamed part lead, become the seat of active congestion, and ultimately of inflammatory exudation. In diphtheria we have an illustration of this general law, for the lymphatic glands, to which the lymphatics of the pharynx, &c. lead, are found to be larger, redder, and moister than natural; and, if the disease has continued long, to have that peculiar brittleness, and pale, but brightish red colour, which are characteristic of the presence of inflammatory exudation in the glands. During life we feel the enlarged lymphatic glands behind the angle of the lower jaw on either side, as well as down the neck by the sides of the larynx when that organ is involved in the inflammation. When the discharges from the pharynx are fetid, and the mucous membrane is sloughy, not only are the glands behind the angles of the jaw enlarged, but the cellular tissue in which they are placed is the seat of effusion of serosity, and even of exudation of lymph, and very great general swelling of the part is the result.<sup>1</sup>

<sup>1</sup> Trousseau attaches much diagnostic value to the enlargement of the lymphatic glands of the neck in diphtheria. I cannot agree with him on

After death from diphtheria, too, we find that the inflammation of the pharynx has not been limited to the mucous membrane, or even to it and the submucous tissue, for the deeper parts are thickened and toughened. The contraction of the exudation poured into those parts is sufficient, in many cases, to diminish considerably the capacity of the pharynx, its mucous membrane being thrown, partly from this cause, and partly from its own swollen condition, into longitudinal rugæ. Acute pulmonary vesicular emphysema, the result of the obstacle to expiration produced by the imperfect occlusion of the larynx and trachea; collapse of lung tissue from the combined effects of lymph or mucus in the smaller bronchial tubes leading to the collapsed tissue, and of the impediment to deep coughing offered by the state of the larynx; pneumonia, lobar or lobular, primary, or, as is more commonly the case, secondary to collapse of lung tissue; some congestion of the spleen, of the liver, and of the kidneys, induced mechanically by the state of the lungs; and enlargement of lymphatic glands at a distance from and no ways related to the pharynx—are all the lesions additional to those constituting its anatomical character, which I have found after death from diphtheria during the present epidemic.<sup>2</sup>

The specimens on the table illustrate much of what I have just told you.

In one (specimen 1) we see the reddened mucous membrane of the pharynx, larynx, trachea, and larger bronchi. On the mucous membrane of the pharynx and larynx is a layer of the granular or pulpy variety of lymph; as we reach the trachea, the lymph gains in consistence, so that, towards the middle of the trachea, it can be raised as a distinct membraniform layer; where it can be so raised, its under surface is, here and there, crimson, from a little blood. The

this point. The enlargement of the glands has been—in the cases of diphtheria which I have seen—in proportion to the severity and depth of the local, nasal, pharyngeal, laryngeal, and tracheal disease. I have never seen it greater in proportion to the local primary mischief, than in other forms of cynanche pharyngea. In children generally, the swelling of the glands, other things being equal, is greater than it is in adults; and in strumous children the enlargement is always greater, other things being equal, than it is in rickety or in healthy children.

<sup>2</sup> I have seen (though not during the last three years) the exudative inflammation spread down the œsophagus and the stomach, and the mucous membrane of those parts, as a consequence, covered with lymph.

uvula is all but *gone* from sloughing, and there is a minute slough on one tonsil. On removing the lymph from the epiglottis, we see a little ulceration of its mucous membrane. The whole tract of mucous membrane covered by lymph is bright crimson and thickened. The microscope shows us that the softest lymph is composed of pus corpuscles—the pyoid corpuscles of Lebert, and other smaller and larger granular corpuscles, epithelium, and oleo-protein granules; and, though we have used reagents to render the animal matter transparent, no vegetable growths can be detected.

In the second specimen we have a good example of the thick, tough, elastic variety of lymph. In both these cases the local disease extended from the pharynx to the larynx, trachea, and bronchi. If you examine the lungs on the table, you will see that the mucous membrane of the first, second, and third divisions of the bronchi is coated with lymph. The largest piece of the tough lymph (specimen 2) is in the form of a hollow tube, and is evidently a cast of the inside of the trachea. Extending from some of the larger portions are branches, which appear to have been formed in the bronchi. I have placed a little of this tough variety of lymph under the microscope, and you will note the imperfectly fibrous appearance it presents.

In the third specimen on the table, the lymph coats many even of the very smallest bronchi, as well as the larynx, trachea, and large bronchi. The presence of the lymph and mucus in the smallest bronchial tubes, dependent partly on the state of the larynx and trachea, preventing deep coughing, has led to the collapse of the lung tissue: pneumonia, lobar and lobular, has followed. The child from which this specimen was removed was the subject of rickets. Its trachea was opened during life. You will observe that there is neither collapse nor pneumonia of the lung in the first case; the false membrane, as it is called, does not extend beyond the larger bronchi, and the lungs are the seat of acute vesicular emphysema.

As the lymphatic glands connected with the pharynx and larynx are still attached, you see that they are considerably larger, as well as redder and more brittle, than they should be. In neither specimen are the tonsils much larger than normal; but all the tissues of the pharynx and soft palate

are thickened in the first specimen; while in the third specimen there is a point worthy of your note, of the highest importance, viz., that, while the larynx, trachea, and bronchi are coated with lymph, there is but a small patch on the pharyngeal mucous membrane; that patch is limited to the posterior wall of the pharynx, and is not in the least degree continuous with the lymph in the larynx. There were here, then, two separate centres of exudation, and the laryngeal exudation occurred for some time before the pharyngeal. The exudative inflammation did not spread from the larynx to the pharynx. The laryngeal symptoms were urgent before the pharynx was in any way affected, and you see most clearly that there is no continuity between the lymph in the larynx and that in the pharynx; that the latter is situated at some distance from the former. In the first case the exudative inflammation began in the pharynx, and spread to the larynx; and we see that the layer of lymph in the pharynx is continuous with that on the larynx, the continuity being well seen on the aryteno-epiglottidean folds. Observe for yourselves the differences in this particular in the two specimens.

The most practical way of making you acquainted with the symptoms of diphtheria, including those which were present in the cases parts of which are before you, will be, I think, to group the cases I have seen, so as to constitute varieties.

**FIRST VARIETY.**—*The mild form of diphtheria.*—There are cases in which the general symptoms and the local lesions are trifling, and no sequelæ follow. Of these mild, but unequivocal cases of diphtheria, I have seen only seven; viz., three out-patients at the Hospital for Sick Children, and four cases in private practice.

Here are the particulars of a case of this kind I saw with Dr. Hawkeley.

The patient was six years of age. She had long had chronic enlargement of the tonsils, and suffered occasionally from acute inflammation of the tonsils. In the attack of diphtheria, inflammation of the mucous membrane covering the tonsils and arches of the palate, but very trifling in degree, preceded for some days the exudation of lymph. When the exudation occurred, it was seated between the uvula and the tonsils, on the anterior arches of the palate. In addition to the exudation of lymph, trifling febrile disturbance, the least possible sore-

ness of the throat in swallowing, and a little more swelling of the glands near to the angle of the jaw that is always present in this child, were all the ailments in the case. Dr. Hawkeley examined the urine daily, but no albumen was present, and no affection of the nervous system followed.<sup>1</sup>

**SECOND VARIETY.**—*The inflammatory form of diphtheria.*—Symptoms of severe cynanche pharyngea precede the exudation of lymph in what may be called the inflammatory form of diphtheria. There is, in this variety of the disease, redness, and swelling of the mucous membrane covering the arches of the palate, the uvula, and the tonsils. The redness is in some cases vivid, in others dusky. The swelling of the uvula is frequently considerable, and it often has, from effusion of serosity into the submucous tissue, a jelly-like transparency and aspect. The pain in the act of swallowing is great, so that occasionally deglutition is, from this cause, almost impossible. The febrile disturbance may be extreme, or moderate; the pulse is frequent, but soon becomes weak; there is considerable sense of weakness and of illness. From twelve to forty-eight hours from the first symptoms of throat affection, a layer, more or less extensive, of tough lymph coats the inflamed surface, and when death follows, it does so from extension of the exudative inflammation to the larynx, trachea, &c.

Let me give you an outline of some cases of the inflammatory form of diphtheria.

Dr. E. called on me one morning, complaining that he felt extremely ill and weak, and that his throat was very sore. I found his pulse rapid, but not strong; his skin hot. On examining his throat the arches

of the palate and all the parts visible beyond were deep but dusky red and swollen—the uvula was cedematous, the effort to swallow caused severe pain. In three days all the previously red parts were covered by a thick layer of tough lymph, having the colour and general appearance of wash-leather. The disease did not extend to the larynx, and Dr. E. recovered.

Mr. A., who expectorated the cast of the trachea on the table, was a patient of Mr. Pearse, of Tavistock Square. Feeling poorly, Mr. A. left home on last Thursday fortnight, for two or three days—on the Monday following, Mr. Pearse examined his throat, found it dusky-red, and the uvula to have that peculiar gelatinous aspect which indicates submucous serous effusion. On the next day Mr. Pearse observed patches of lymph on the right tonsil and on the uvula. On Friday, not only was there a layer of lymph covering the uvula, arches of the palate, part of the soft palate, and the pharynx, but, by depressing the tongue, we could see the erect epiglottis covered with the same tough lymph. That the patient's larynx was affected was shown by his husky whispering voice, the necessity he was of sitting erect in bed, the recession of the soft parts of the chest walls when he inspired, the lengthened inspiration, the lividity of his lips, the fulness of his eyes, and the venous injection of his conjunctivæ.

His urine was loaded with lithates; it contained a considerable quantity of albumen, and a very few granular casts of tubes. There is a specimen of the urine on the table, and I have placed some of it under the microscope. A large number of crystals of uric acid have formed in it since it was passed. On Saturday night he coughed up the cast of the trachea on the table, with temporary relief to the breathing. Many large pieces of membraniform lymph were coughed and hawked up the next day, but on Sunday afternoon he died somewhat suddenly. His pulse on Friday was 120; on Saturday 130; and on Sunday midday as frequent. Of seven cases I have seen referable to this variety, three proved fatal; one forty-eight hours from the first symptom, and one (Mr. A.'s) so late as the eleventh day of illness,<sup>1</sup> and all by extension of the exudation to the larynx.

<sup>1</sup> This variety of diphtheria is doubtless more common than my personal experience would lead me to suppose. It is probable, also, that there are many inflamed throats which have their origin, when diphtheria is epidemic, in the diphtheria miasm, whatever that may be, just as many cases of diarrhoea originate in cholera miasm, when that disease is epidemic. And it is as difficult to say in some cases that an inflamed pharynx is not due to mild diphtheria, as it is to say that a serous diarrhoea is not cholera. Of course one or more members of a family having exudation on to the pharyngeal mucous membrane, and others at the same time having merely inflamed throats, would be strong presumptive evidence that the latter had diphtheria without exudation. As when two children of a family have scarlatina with rash, and a third, at the same time, just before, or just after, has sore throat without rash, we consider there is strong presumptive evidence that the latter was a case of scarlatina sine eruptione. In describing diphtheria in these lectures, however, I have drawn my description from those cases only in which exudation has occurred.

<sup>1</sup> If the diphtheria began on the Monday, then Mr. A. died on the seventh day of illness.

The following is a mild case of the inflammatory form of diphtheria: Eliza R., aged 20, had been in constant attendance on Dr. E. On March the 13th, 1858, she began to feel ill, with sense of weakness and general lassitude. Her throat at this time was slightly sore; her skin was hot, her pulse quick, her bowels confined; she was thirsty, without appetite, and had constant nausea. I saw her on the 18th, when there was, in addition to these symptoms, a patch of lymph on the left tonsil which was red and swollen. On the 20th, she was admitted into this hospital. On this, the eighth day of illness, her skin was still hot, and her pulse frequent but not particularly weak. There was some swelling and tenderness just outside the angle of the jaw on the left side, the lymphatic glands down each side of the neck were enlarged and tender, deglutition was painful, and the voice was hoarse. The patch of lymph noted on the enlarged left tonsil on the 18th had increased in size; it was removed by a pair of forceps, and a raw, red, bleeding surface was exposed. The arches of the palate were very red; and the tongue was covered with a white fur; there was no albumen in the urine.

When rapidly convalescing from the diphtheria, she had, on the 24th of March, an attack of acute rheumatism, from which she recovered in little more than a week, and left the hospital well.<sup>1</sup>

I must add yet one other case of this form of diphtheria, the constitutional disturbance in this case being even less than in Elizabeth R.

Thomas C., aged 33, a night railway-porter, a strong made and generally healthy man, was admitted into this hospital on Sunday, April 4th. 1858.

This man awoke at nine o'clock on the morning of his admission into the hospital (having felt quite well on going to bed a few hours before) with a sensation of "swelling in his throat." The effort to swallow caused intense pain. The surgeon, whom he at once consulted, touched his throat with nitrate of silver. At one o'clock he was seen by my assistant, Dr. Pougnet; the uvula was then so enormously enlarged, "as thick as the little finger," that he could not see into the pharynx.

<sup>1</sup> In one case several joints were swollen, hot, and tender during the attack. The patient recovered.

I saw the man on Monday, i. e. the second day of his illness. The uvula was as large as on his admission; its anterior surface was covered with lymph, and when it was raised, on its posterior surface was found a transparent whitish layer of lymph which could be peeled off with a pair of forceps. There was a small patch of lymph extending from the uvula on to the soft palate, which was generally of a bright red colour. The pharynx and tonsils were free from lymph. The lymphatic glands at the angles of the lower jaw, and down the neck on each side of the larynx, were larger than natural, and tender. On the next day the uvula was unchanged in appearance, but the arches of the palate were very red, and dotted over with small patches of opaque white lymph. On Wednesday, i. e. the fourth day of disease, the uvula had diminished in size, but the exudation on it formed a thick tough layer. There was a small patch of lymph on the right tonsil. The pain in deglutition was still very great.

On the sixth day the man's general state and local lesion had considerably improved; he looked much better.

Up to this time his pulse had ranged from 88 to 96, and on the fourth day it was noted to be full and hard. The temperature ranged from 99° to 100° Fahrenheit, and on the fourth and fifth days the skin was noted to be hot and dry: before and after that it felt cool to the hand.

On the tenth day the man was almost well, only his uvula was rather redder and larger than natural.

**THIRD VARIETY.**—*The insidious form of diphtheria.*—In the cases referable to this head there is no severity in the general symptoms, no marked soreness of throat, no notable swelling of the lymphatic glands, but suddenly and, if the pharynx has not been examined, unexpectedly, laryngeal symptoms supervene, and death rapidly follows from suffocation. If the pharynx be not examined the disease is confounded with primary croup.

A child, aged about six years, living in a villa near the Brecknock Arms, had suffered for some days from slight sore throat, but was not thought to be sufficiently ill to require medical advice, or even to be kept in the house, when the sudden occurrence of "croupy" breathing excited alarm. Mr. Baly, of Kentish Town, was called to the child. He found that the pharynx was



covered with lymph, and that the larynx was deeply involved in the disease. About two P. M., within an hour of Mr. Baly's first visit, I saw the child with him; the friends declined to allow tracheotomy to be performed; the same afternoon the child died.

Ten days since I saw a similar case a few hours before death, with Mr. Noyce, of Brecknock Crescent. Several children of the family had just suffered, and recovered without treatment, from sore throat. They had been, in the parents' estimation, worse than was our little patient (æt. 6), when her croupy breathing excited their alarm. The friends declined to allow tracheotomy to be performed, and the child died within forty-eight hours from the supervention of the first laryngeal symptoms.

A child, aged about six years, had suffered for two or three days from sore throat. The surgeon who saw the child before the father left home in the morning assured him that the disease was trifling. On the father's return, late at night, the croupy breathing excited his alarm. I saw the child, with the surgeon, about midnight. There was then rapid pulse, husky whispering voice, shrill respiration, and great dyspnoea. Before seven o'clock in the morning the child was dead.

The infant child, aged eleven months, of a surgeon, had for a day or two slight symptoms of sore throat. The father's fears, although he is an anxious parent and a most intelligent and experienced practitioner, were not excited till between ten and eleven at night, when he noticed for the first time laryngeal breathing. The extreme recession of the softer parts of the chest walls during inspiration proved the impediment to the passage of the air through the larynx. There was a little lymph on the pharyngeal mucous membrane when I saw the child about eleven P. M. Before morning it was dead. These cases will impress on you the importance of examining carefully the pharynx in every case, even the most trifling, of sore throat.

**FOURTH VARIETY.**—*The nasal form of diphtheria.*—Another set of cases constitute what has been termed the nasal form of diphtheria. After some febrile disturbance of low type, a sanious discharge from the nose attracts attention; then the glands about the angles of the jaw swell; the arches of the palate and the tonsils are

found to be red and swollen; muco-purulent fluid bubbles in quantity from the narrow isthmus faucium, and prevents you obtaining a clear view of the pharyngeal mucous membrane. After a few days the disease subsides, and you remain in doubt as to its nature; or it spreads to the larynx, and the diagnosis becomes easy, and death enables you to verify it; or some other member of the family or an attendant sickens with unmistakable symptoms of diphtheria. Or the disease begins with trifling sanious discharge from the nares; the lymphatic glands are scarcely at all affected, and the nature of the disease is not even suspected till death is imminent from suffocation; or again, when the exudation reaches the pharynx, the pharyngeal symptoms may be most distressing, and lead to inspection of the part and the detection of the disease.

In November, 1859, I saw, with Dr. Carlill, of Berners Street, a very interesting case of nasal diphtheria, remarkable especially for the difficulty of the diagnosis, even at a time when serious symptoms were present. The patient was a girl aged two years. The parents first observed that the child had a little sanious discharge from the nose, and was very decidedly out of health. The discharge from the nose had ceased when I saw the child. There was no enlargement of the lymphatic glands of the neck. The great feature in the case at that time was frequent vomiting. Almost every attempt to swallow was followed by efforts of vomiting, and the forcible ejection of fluids through mouth and nose. As the vomiting seemed sometimes to come on before the fluids could have reached the stomach, the throat was inspected by both Dr. Carlill and myself; nothing wrong in it could, however, be detected. Although the nature of the case was obscure, the whole group of symptoms present led us to the opinion that they were the consequence of disordered innervation from cerebral disturbance, rather than the result of any throat affection. "Two days," Dr. Carlill wrote me, "after you visited her, I saw a thin pellicle partly covering the velum pendulum palati, and partly detached and hanging down into the mouth. She died the next day, never having been able to swallow more than a small part of what was given her for about six days." The immediate cause of death was the

extension of the exudation to the larynx; the child died from suffocation, as in primary croup.

The following case of nasal diphtheria possesses special interest from the chief evidence in favour of the diagnosis being the communication of the disease to another—just the kind of evidence which we consider conclusive in regard of the nature of some obscure cases of scarlet fever.

Master P., aged about two years, suffered some febrile disturbance of low type, and profuse muco-purulent discharge from the nares, and redness and swelling of the velum pendulum palati, uvula, arches of the palate, and tonsils; the posterior wall of the pharynx was not very clearly to be seen, in consequence of the large quantity of muco-purulent fluid that bubbled in the pharynx. Dr. Carlill, whose patients this little one and his brother, less severely but similarly affected, were, thought the cases were true diphtheria. I had considerable doubt on the point. At any rate, as we could see no lymph, and the larynx was not affected, I hesitated to admit it. Dr. Carlill was in attendance from the 15th to the 28th of March, 1860, and a lotion was injected into the nares and throat by Dr. Carlill daily, from the 15th to the 25th. On two occasions Dr. Carlill remembered distinctly that the child coughed some sputa into his face. On April 2d, Dr. Carlill was himself attacked by diphtheria.

Had the child whose case I am now about to relate recovered, and had not the child in the next bed suffered within a few days from unquestionable diphtheria, doubts as to the nature of the disease under which it suffered might have been felt.

William W., aged two years and three months, a delicate child, the subject of rickets, was admitted into the Hospital for Sick Children on the 31st of December, 1860, the rash of measles having appeared on that day. The rash came out full and well; from the first there were abundant sonorous and mucous rhonchi audible over the whole chest. On the 3d of January, that is, the fourth day of the eruption, there was much discharge from the nose, and a little ulceration of the orifice of the nares. His appetite was good, there was no difficulty in swallowing; the skin was very hot.

By ten o'clock the same night a marked change had taken place in the child, and

the following notes of its state were made by Mr. Sydney Ringer, the very able Medical Registrar to the Hospital:—

"Child prostrate; pulse 160, weak; respirations hurried but not laborious; no lividity of the face or body. Abundant dirty muco-purulent discharge from the right nostril. Fauces, uvula, and tonsils red, and very much swollen, and covered with thick tenacious mucus. No exudation can be seen, but then the thick mucus in the pharynx prevents a perfect inspection of the parts." At nine A. M. the fifth day of eruption, the child was weaker, but could still swallow solids and fluids, and apparently without difficulty. The eruption was well out.

About one P. M. the nurse raised the child's head, in order to give it some food—it fell back and died without a struggle.

The body was examined the next day.

The lungs were the seat of extensive acute emphysema, and of a little collapse. The lymphatic glands along the trachea were not enlarged; those behind the angles of the lower jaw were only just perceptible to touch before the integuments over them were divided. The whole substance of the *velum pendulum palati* and uvula was considerably thickened and toughened. The cavity of the pharynx was smaller than natural, the mucous and submucous tissues thickened; the mucous membrane was bright red, and elevated into rugae. Here and there, on the surface of the mucous membrane at the upper part of the pharynx in the vicinity of the posterior nares was a little lymph, granular in form, very soft, and easily removed by scraping with the knife, nowhere forming a continuous layer. The *aryteno-epiglottidean* folds were greatly thickened, the epiglottis also decidedly but less thickened. The mucous membrane of the larynx was less smooth and polished, and at the same time redder than it should be, and the *chordæ vocales* were more spongy looking than natural. The abnormalities of the larynx were all insignificant in degree—perhaps such as are often present in measles. The lesions of the upper part of the pharynx were decided, although still trifling; they were the result of nasal diphtheria complicating the measles. The child probably died at so early a period of the diphtheria, in consequence of the weakness resulting from the severe attack of measles under which it was suffering at the time the



diphtheria supervened, and its natural delicacy of constitution (it was not only ricketty but also tubercular). The cause of death was asthenia.

As if to prove to us the nature of this case, the child in the next bed sickened with well-marked diphtheria within twelve hours of William W.'s death. In twenty-four hours from the first symptoms of illness, its trachea was opened by Mr. Berkley Hill, death by suffocation being imminent. I shall describe this case at some length in my next lecture when speaking of the value of tracheotomy.

**FIFTH VARIETY.**—*The primary laryngeal form of diphtheria.*—I have seen three cases in which the exudation seemed without doubt to occur first in the larynx, the pharynx being subsequently affected. We may call this primary laryngeal diphtheria. In one of these cases the patient was a medical man, about forty-five years of age. The disease began with pain in deglutition, and redness and swelling of the mucous membrane of the pharynx, arches of the palate, uvula, and soft palate. Laryngeal symptoms rapidly supervened; then a little lymph was seen on the arches of the palate, the exudation being more abundant at the base of the arch than above, and equal on the two sides; it looked as if it had spread upwards from the larynx. The patient would have died from apnoea had not the larynx been opened on the third day of illness. During the second week of illness, he almost died from asthenia.

Another case was that of the child whose pharynx, larynx, trachea, &c., are on the table (Specimen 3). I described the parts to you early in the lecture.

In all the varieties of diphtheria I have described, the disease when fatal proved so in consequence of exudative inflammation affecting the larynx. The patient dies in such case from the impediment to the entrance of the air into the lungs. In the variety of which I am now about to speak, the patient, when the disease proves fatal, dies from the general disease.

**SIXTH VARIETY.**—*The asthenic form of diphtheria.*—In this form the disease begins sometimes with general and local symptoms of moderate severity. Soon, however, the pulse is rapid and feeble; the sense of weakness and of illness extreme; the skin is not very hot, but there is a peculiar feverish pungency in its heat as appreciated

by the touch; the complexion has that dirty-looking, pallid, and opaque aspect which we see in so many general diseases. In some cases, from an early period of the disease, the brown tongue, the sordes on the teeth, &c., and the muttering delirium which are characteristic of the so-called typhoid condition, are present. On examining the throat, more or less lymph is seen on the pharyngeal mucous membrane. The lymph in these cases has always, in my experience, been of the granular, pulpy, or softer form. The patient may swallow with perfect facility and the throat symptoms be trivial in degree, and this even when the pharyngeal mucous membrane is covered with lymph. In other cases the pain in deglutition is extreme. The extension of the exudative inflammation to the larynx, when it occurs, is shown by a little huskiness and want of power in the voice, and imperfectly marked laryngeal breathing. The patient usually dies in about ten or twelve days, death being the result, not of apnoea, but of asthenia. It is failure of the heart's action and not want of breath that causes death.

I saw a case referable to this head with Dr. Turle, of St. John's Wood. The patient, a little girl aged eight years, lived at the extreme verge of London in that direction. She had been poorly for a few days when seen by Dr. Turle. The friends said there was only slight sore throat and weakness.

Dr. Turle noted, on the 6th of October, 1859, "skin not only hot, but feverishly pungent, slightly furred tongue, some enlargement of the glands behind the angles of the jaw, and all the parts of the pharynx visible to the eye covered with lymph." On the 12th the urine contained a good deal of albumen. On the 15th I saw the patient; there was then evidence of extension to the larynx, but the laryngeal symptoms were not at all urgent. On the 18th death occurred, as Dr. Turle says in his notes of the case, "from exhaustion, and not from asphyxia."

The following case is remarkable for the rapidity with which the disease ran its course, the early delirium, and the severity of the general symptoms. Although the larynx was severely affected, it was manifest that its lesion played but a small part in causing death. Had the general derangement been less, no doubt the affection of the larynx would soon, however, have

formed a prominent feature in the case, and even have led to a fatal termination in another twenty four hours.

Henry M., aged 17 years, was in good health on Friday night, February 12, 1858. He had spent the evening in society, and sung a good deal. The next morning he had sore throat and difficulty in swallowing; slight cough; he vomited, and felt cold and shivered. By noon he was unable to swallow; at night his breathing became difficult, his breath offensive, and he was delirious. On the 14th he was still unable to swallow, could not get out of bed without assistance, and was delirious. At two P. M. on the 14th, he was carried to my ward in this hospital.

Soon after his admission, Dr. Pougnet found him in a very prostrate condition, lying on his back, and muttering deliriously. He could not be made to answer questions, or to protrude his tongue; and as he resisted all attempts to open his mouth, the state of his pharynx could not be seen. But as there was swelling about the angles and under the rami of the jaw and down the neck, the breath had a gangrenous odour, and there was profuse discharge of yellowish offensive fluid from the mouth, and no rash on the skin, and as he had not been exposed to the scarlet fever poison, the diagnosis of diphtheria, although not absolute, was highly probable. His face was puffy, his lips blue, his pulse frequent, small, and weak. He died the same night; thirty six hours only from the first symptoms of disease.

After death the mucous membrane of the pharynx was found dark crimson gray in colour, and covered over its greater extent by a layer of the granular variety of lymph. The capacity of the pharynx was less than natural, in consequence of oedematous thickening of the submucous tissue and corrugation of the mucous membrane. The *velum pendulum palati* was greatly thickened, and the posterior surface of the uvula was covered with lymph.

The upper and under surfaces of the epiglottis, the aryteno-epiglottidean folds, and the mucous membrane covering the larynx above and below the vocal cords, the trachea, and the first division of the bronchi were covered by the soft form of lymph. The lungs were the seat of acute emphysema.

In a case I saw with Dr. Part, of Camden Road Villas, the young lady, about 18 years of age, exhibited no laryngeal symptoms.

When Dr. Part first saw her on December 17, 1858, there was very trifling sore throat, with little or no constitutional disorder. The febrile disturbance throughout was extremely trifling, and although the mucous membrane of the pharynx was soon covered with a creamy-looking layer of lymph, the patient swallowed both liquids and solids without difficulty. The pulse was from the first very rapid and weak. At our last visit, on the afternoon of the 26th December, Dr. Part and myself were accompanied by a surgeon who had seen little of the disease in this epidemic. The patient had eaten some chicken for dinner; she sat up in bed, and, though very anxious about her own state,<sup>1</sup> laughed, and talked to us without difficulty.

Dr. Part and I agreed that she had not many hours to live, so rapid and so feeble was her pulse, notwithstanding the quantity of support she was taking. The surgeon, who had not felt her pulse, and judged alone from her aspect and voice, said, "I should have had no idea she was in great danger." In twelve hours she was dead. The illness in this case lasted ten days.

There is yet another set of cases in which death appears to result from the evils consequent on the absorption of fetid matters from the pharyngeal tissues. The pharynx is covered with lymph, the mucous membrane below sloughs, the breath is very offensive, the glands about the angles of the jaw swell extremely, the cellular tissue in which they are imbedded is the seat of the effusion of a serosity, the skin assumes that dirty yellowish tint which it has in septicæmia, the mind wanders, and the patient rapidly sinks.

I trust you will not fail to understand that although I have described to you several varieties of diphtheria, there is no sharp line of distinction between them, any more than there is any sharply-defined line of demarcation between scarlatina simplex, scarlatina anginosa, and scarlatina maligna. You may say this is a case of inflammatory diphtheria, and this of nasal diphtheria, and this of asthenic diphtheria; but you will meet with all intermediate shades of the disease; cases which you cannot refer with certainty to one or the other variety. So we meet constantly with cases of scarlet fever which cannot be referred to either variety, but which combine in themselves

<sup>1</sup> Her sister had died just before of diphtheria.

the essential characters of two. The acute specific diseases are really different one from the other. Each variety of each acute specific disease passes insensibly into the other varieties of the same disease; and these several varieties of each exhibit the most protean combinations. Still, for those who desire to draw a picture of these diseases for others' use, the division of each acute specific disease into varieties is a necessity, however artificial and imperfectly defined the varieties may be.

The duration of the cases of diphtheria I have seen has varied from forty-eight hours to fourteen days. When fatal within a week from the first symptoms of illness, death has always been preceded by extension of the exudative inflammation to the larynx. I have never known laryngeal symptoms commence after the expiration of the first week of the disease. As I have pointed out to you, laryngeal symptoms are sometimes present from the outset; at least they are now and then the first symptoms to attract the attention of the patient and his friends. I have twice seen death occur within twelve hours from the time the laryngeal symptoms were first noticed, and I have never known death delayed more than five days from the time when symptoms indicated clearly that exudation had occurred in the larynx. In rather more than half of the fatal cases of diphtheria I have seen, death resulted directly from the disease of the larynx; and in rather more than half of the remainder, laryngeal disease was present, although death resulted apparently from asthenia. When death has occurred from asthenia the fatal result has usually taken place during the second week of the disease, unless the patient has been greatly weakened by previous disease; thus I have just seen diphtheria occur in a girl aged ten years, who had long suffered from hip disease with profuse fetid discharge, &c. She died from asthenia with rapid feeble pulse on the 5th day of the disease. In the very remarkable case of Henry M., aged seventeen years, you will remember the disease terminated from the severity of the general affection in thirty-six hours after the occurrence of the first symptoms of illness.

The specific disease in the not-fatal cases I have seen has terminated between the eighth and fourteenth day of illness.

NOTE.—An examination of the cases recorded in Bretonneau's *Memoirs on Diphtheria*, fully

confirms the conclusions I have arrived at from my own experience, as to the proportion of fatal cases in which the larynx suffers so as to lead to death; as to the period of the disease at which the larynx becomes affected; and as to the duration of the fatal cases when death occurs from laryngeal complication. Thus, in Bretonneau's 1st, 2d, and 4th *Memoirs*, are contained the details of forty-five cases; of these, four are wanting in data, or have no bearing on this subject. In twenty-nine of the remaining forty-one cases, the larynx was the seat of disease, and three only of the twenty-nine ended in recovery.

Of the twenty-six cases—fatal from the laryngeal complication—one terminated on the second day of illness, one survived till the sixteenth day of illness—tracheotomy having prevented death on the fourteenth day. In no case did the patient survive the sixth day of the laryngeal symptoms unless an operation retarded death, and in five only of the twenty-six cases did the patient survive the third day of the laryngeal symptoms.

In all of the twenty-nine cases, excepting one, the laryngeal symptoms supervened before the end of the first week, and in sixteen of the twenty-nine cases on or before the third of illness.

The emphysema of the lungs seen after death from diphtheria, is that which is so commonly found in young children. It is a mere over-distension of healthy air-vesicles. Gluge terms it insufflation. We can produce it by inflating the lungs after their removal from the body; or, by compressing one part of a lung, we can drive enough air to other parts to over-distend their air-vesicles, and so produce a condition identical with acute vesicular emphysema. As there is no damage to the texture of the lungs in this form of pulmonary emphysema, the air-vesicles recover their normal size when the over-distending force is removed. Bretonneau describes a case of diphtheria in which, not only were the air-passages and the air-vesicles over-distended, but one or more gave way, and air was extravasated into the subcutaneous tissue. Trousseau has recorded a similar case. The latter distinguished pathologist attributes the subcutaneous emphysema to violent inspiratory efforts. This is manifestly an incorrect explanation of the facts. There is no power brought into play during inspiration to draw the air into the subcutaneous tissue. It is during the expiratory efforts that the air, unable to escape freely through the larynx, is driven with such force into the least compressed and least supported parts of the air-passages and vesicles as to over-distend them, to rupture them, and to inject the air into the cellular tissue. The same accident, as is well known, sometimes happens, from the same cause, during the violent efforts of parturient women. Doubtless the extreme inflation of the lungs when false membrane exists in the larynx and trachea, is partly the result of accumulation of air in them; the false membrane acting, as Bretonneau says, as a valve, permits air to enter but none to escape.

#### HOSPITAL NOTES AND GLEANINGS.

*Diabetic Cataract.*—In the *Ophthalmic Hospital Reports*, vol. i. p. 273, for January, 1859, is a paper by Mr. France, in which he drew the attention of the profession to the relation sometimes existing between cataract and diabetes. Previous to this, there had been scattered in the works of ophthalmic writers and others, mention of the coincidence. In a second paper on the same sub-

ject in Guy's Hospital Reports, Mr. France names Mackenzie and Duncan, as having incidentally alluded to it, and subsequently to his paper Professor Von Graefe, and Dr. Willshire, have written on the subject. Mr. France has from various sources collected twenty-one cases, and from the consideration of them, he arrives at the following conclusions:—

"The cataracts have in every example been symmetrically developed on both sides; the lenses have increased remarkably in their antero-posterior diameter, so as to encroach upon the depth of the anterior chamber, and even to interfere mechanically with the free play of the iris. The opacity has attacked portions of several strata of the crystalline at once, leaving intermediate spaces for a while transparent. The colour and bulk of the cataracts have invariably indicated their soft consistence, which was proved by operation in two persons, though respectively of 'middle' and of forty-eight years of age. Lastly, the ocular affection has only arisen after considerable duration of the renal malady (a circumstance which may tend in some degree to account for the comparative rarity of their union); and there has in no case been reason to suspect further disease of the eyeball."

The following case is extracted from the writer's note-book, under date August, 1850, at which time the patient was an inmate of the York County Hospital. At that time, the knowledge of the connection between diabetes and cataract had been scarcely mentioned in print. It was, however, well recognized by many practical surgeons, and among others, by Mr. Russell, under whose care the patient was. We well recollect his adverting to the fact of the occasional concurrence of the two diseases.

E. P., aged 19, was admitted Aug. 22, 1850. She had been the subject of diabetes for five years. She was pallid and extremely ill. Her tongue was red, and she was liable to occasional diarrhoea. Her skin exhaled the peculiar odour of diabetes. Her appetite was inordinate. The urine was large in quantity, and loaded with sugar. There was evidence of tubercular disorganization in the apices of both lungs. Both lenses were opaque. In the right, the opacity appeared to be in front of the lens, while in the left, in which the opacity was

much slighter, it appeared more distant. She remained in the hospital about four months, during which time the cataracts advanced, and she became almost blind. She could still, however, distinguish between light and darkness. Various tonics, cod-liver oil, creasote, opium, etc., had been used, but without any permanent advantage, and the quantity of urine never permanently diminished, and the specific gravity did not decrease. She at length left the hospital, in order to die at home. It is, perhaps, worthy of note that the patient attributed her first failure of health to her having lived in a situation where she was obliged to be up for several hours before taking food.

The subject is one of great interest in another way, as illustrating the value of the study of disease by synthesis.

Dr. B. W. Richardson has shown that artificially produced cataract occurs as a purely physical change—from osmosis—a tendency to equalize the density of the fluids within the lenticular capsule, by transudation to the surrounding fluids, for he observes that the cataractous condition can be removed by reversing the conditions—by placing the animals experimented on in water. All varieties of sugar, cane, grape, and sugar of milk, produce the same result. Just, however, as we find that in many cases of cataract there is no diabetes, so Dr. Richardson found that the introduction of other substances into the system than sugar would produce cataract. Thus salines, as chloride of sodium, would develop the cataractous condition, and hence Dr. Richardson's remarks—"There may be a saline cataract as well as a diabetic one."

Sugars and the various salines produced the same general effect, with the exception of the iodide of potassium. This salt did not produce any effect in any instance. Dr. Richardson says: "I do not pretend to explain this curious and remarkable fact." Chloride of sodium, a salt of the same chemical type, readily produces cataract.

In the majority of instances the opacity begins at the posterior surface of the lens, but sometimes in the anterior surface. The capsule of the lens is unaffected. Dr. Richardson found sugar in the opaque lenses after removal. There was always a difference in the general character of the opacity produced by various substances. As a rule, the opacity became more marked after death; but in the case of the sulphate of

potash it disappeared altogether. Dr. Richardson says we should look for cataract especially in those cases in which profuse diuresis is absent; for in those in which the sugar is eliminated as fast as it is manufactured, no cataract is likely to be formed: for as he points out, sugar produces cataract by increasing the specific gravity of the fluid, and not by any specific power. He reminds us that we may find that an opposite condition of the fluids may exercise a deleterious influence on the lenses, not by impairing their clearness, "but by excessive transudation (endosmosis) and distension."

Opacity of the lenses may be produced by saline and saccharine fluids introduced into the anterior chambers of the eyes of animals recently killed, or by immersing the removed eye in the solution. In these experiments, however, the effects were much more slowly produced, and the changes were less intense.

Dr. Richardson also experimented with the acid urate of soda. The salt was suspended in water by gum Arabic (the injection of gum does not produce cataract), and injected under the skin of two frogs. In neither of these experiments was any opacity of the lens produced. He also gave a bitch night and morning with her food a drachm and a half of urate of soda, and after a week the quantity was increased to two drachms. She took this for fifteen weeks. The experiment was commenced on March 2. In April, it was evident that the animal was becoming blind, and "the eyes through the pupil were opaque-looking, and the animal ceased to observe objects, even those near her." The eye was, however, examined by the ophthalmoscope by Mr. Wordsworth, and no cataract was discovered, except the merest opacity in one lens. Mr. Wordsworth believed the white appearance to depend on white discoloration of the retina. When the urate was given up, the animal recovered her sight gradually, and ultimately could see as well as ever.—*Med. Times and Gaz.*, March 9, 1861.

**Rare Form of Fibro-muscular Subclavicular Tumour.**—The following singular case recently presented itself at Middlesex Hospital. The patient is a delicate, sickly-looking woman, about forty years of age, who, four months before admission, received

a blow on the chest, immediately below the right clavicle towards the sternum. This was followed by the appearance of a lump, which slowly enlarged, until it had attained the size of a hen's egg; but the swelling was somewhat diffused, as the tumour itself was evidently deep-seated, and now, was somewhat prominent below the clavicle. She had also a swelling, of the size of a walnut, flattened, on the side of the right ramus of the lower jaw. The subclavicular tumour seemed to be of unequal density, and consisted of lobes; there was a deep feeling of fluctuation. In ten days it had decidedly increased in size, and formed apparently adhesions to the clavicle. Various opinions were hazarded as to its real nature: its deep situation, apparent fluctuation, and supervention upon a blow, led to the suspicion that it might be strumous deposit with matter, but a puncture was followed by nothing but a drop or two of blood; it might be medullary, or, again, fibroid or fibro-plastic. Its removal, however, was determined upon; and after much patient and careful dissection, on the 28th of November, by Mr. Moore, it proved to be an infiltration of the pectoralis major muscle itself, with fibrous deposit. The superficial parts were healthy, but beneath it simulated an aneurism; in fact, on section, a yellowish mass, of firm consistence, was found to be present in the centre, which resembled the clot of an old aneurism; and towards the circumference this was blended with the muscular structure. The microscope revealed this to be nothing but fibrin, which had infiltrated the muscle, and formed a large and distinct mass, which had become organized in the form of a tumour. There was no artery discovered in connection with it, although Mr. Moore carefully dissected it away from the inner and under parts. The nature of the tumour thus proved to be purely fibrinous, running into the fibres of the muscle named, beneath which it lay, as well as extending under the clavicle.

Its appearance before the operation strongly simulated malignant disease, and considering the woman's age, cachectic aspect, and the presence of another tumour in the jaw, together with the rapidity of growth, the majority of surgeons would have pronounced its nature cancerous. The skin was moreover discoloured, and the swelling to the naked eye was that of disseminated medullary deposit. The case is assuredly



an instructive and interesting one. The patient has done very well, and made a good recovery.—*Lancet*, March 16, 1861.

*Recurrent Melanosis of both Groin and Back; the disease reappearing in the brain, heart, pancreas, liver, and other organs.*—Geo. K., aged 35, was admitted into St. George's Hospital on the 9th April, 1856, for melanotic tumours in various parts of the body, and especially in the groin. Some of these were removed, and the patient recovered from the effects of the operation, permitting of his discharge on the 11th of June. On May 28th, before leaving the hospital, he was seized with great pain in the head, accompanied by severe and persistent vomiting. His countenance assumed a very strange, vacant expression, and he seemed to have some difficulty in collecting his thoughts when spoken to. These symptoms passed off in about five days; and on his departure the tumours on the back seemed to be growing.

He was readmitted on the 14th of July. The complexion was now more sallow than before; the tumours in various parts of the body (trunk, right axilla, left ham and thigh, &c. were growing rapidly; the pain in the head had recurred frequently, and had latterly become much more severe and continuous. He complained of loss of motion in the right hand and arm, and the mouth was drawn to the left side. The right side of the face had lost expression. There was also partial loss of sensation in the right arm and leg. He alleged that he observed double vision when the pain in the head was very bad. The speech was slow and hesitating. On the day before his readmission he had had several seizures of shaking of the right arm.

*July 16th, 1856.* The vomiting of green bilious fluid, which had troubled him before, has recurred, and persisted for a week. After this, till the day of his death (28th), he used occasionally to vomit his food; but was otherwise better.

On the evening of the 28th he died suddenly. During the previous day it was observed that the right eye had been kept closed (it should have been noticed that there was slight ptosis on each side on his readmission), except during the exertion of speaking, when he opened it. He had, however, spoken seldom, and seemed very lethargic. Shortly before his death, he sud-

denly turned purple, and this dark tinge of the face increased up to his death, which was preceded by some strange noises in his throat, and by struggles as if for breath. No regular fits were observed.

*Post-mortem Examination.*—The body was pale and emaciated. Tumours of small but variable size were found on the trunk, in the right axilla, and in the left thigh and ham. There was no fluid, nor were there any adhesions, in either pleural cavity. At the back part of each cavity a few small tubercles of mixed melanotic and encephaloid cancer were found in the subpleural and areolar tissue. The surfaces of both lungs beneath the pleura were studded with small deposits of a similar character; in other respects these organs were healthy. The bronchial glands on both sides were infiltrated with the same deposit to a very considerable extent. The glands, also, in the posterior mediastinum were similarly affected. In the substance of the heart on the right side, and projecting into the right cavities, were several small masses of encephaloid deposit; on the left side the deposits were chiefly of a melanotic character. In other respects the organ was normal. There was a small encephaloid tumour near the anterior margin of the right lobe of the liver, and a larger one, about the size of an orange, near the same point. The stomach was quite healthy. Numerous small nodules of encephaloid and melanotic malignant deposit were found in the substance of the pancreas. Several masses of melanotic cancer, of varied form and size, were found connected with the omentum and mesentery; one, attached to a portion of the mesentery near the small intestine, was about the size of a small apple, and pedunculated. The right kidney was very much congested, the medullary cones being almost of a black colour. The left kidney was enlarged to the size of a cocoa-nut; on cutting into it, the cortical and medullary portions were found wanting, a mere cyst remaining full of soft melanotic deposit. The lumbar aortic glands—those accompanying the right external iliac artery, as well as those in the inguinal canal and in the inguinal region—were found extensively infiltrated with melanotic cancer. The scalp and cranial bones were quite natural. The cerebral membranes were all normal, excepting opposite two small portions of the left cerebral hemisphere—namely, at the anterior extremity, and at



the posterior and upper part. At these parts the arachnoid membrane and dura mater were thickened, hardened, and opaque. Corresponding to the altered condition of the membranes at these parts, the subjacent brain was found to be of a dark reddish brown colour and very firm; and this was owing to the presence of two rounded, well-defined masses of carcinomatous material, each of about the size of a bantam's egg, occupying at these parts the superficial portion of the brain, and involving also the surface itself. The cerebral ventricles contained more than an ordinary amount of fluid; but nothing beyond the above masses of an unusual character was found about the brain. The carcinomatous deposit was of the melanotic form, excepting in one or two small places where no dark colour existed, and where it was of a cream colour. The true nature of the cancerous and melanotic disease was determined by microscopical examination.—*Lancet*, March 16, 1861.

*Chorea.*—Chorea is a disorder which seems to find a congenial soil in Birmingham. It is by no means uncommon to see six or seven, or even more, cases in either hospital at one time. Thus a reference to the last statistical report of the general hospital shows that seventy-six cases were treated during the year ending midsummer 1860. This frequency of chorea generally attracts the attention of practitioners who, before coming to Birmingham, have been accustomed to look upon it as a somewhat uncommon disorder. Dr. Maxwell, the intelligent resident medical officer at the General Hospital, consequently found no difficulty in collecting thirty-five cases in which the well known coexistence of rheumatism was ascertained. But it is certainly very remarkable that, with three or four exceptions, these cases were unselected, comprising in fact all that had been treated at the general hospital in the last four months. Dr. Maxwell believes that a more searching investigation than is commonly instituted never fails to elicit a rheumatic history—fever, arthritic pains, and sweating—at some period of the nervous attack, or immediately before its commencement. He therefore holds that the connection between the two disorders is an essential rather than an accidental one, being thus in accordance with the views of M. Sée and Dr. Todd. Never-

theless, further observations are necessary upon this point, since the last twelvemonth has been unusually productive of rheumatic fever; and we should, therefore, be prepared to find that the combination of the two disorders, even if an accidental one only, had been more than commonly frequent. Another fact of great interest as well as novelty, was the frequent localization of chorea and rheumatism in the same limb, other parts being affected either not at all or in an inferior degree; this the author of the paper had frequently seen. He lauded arsenic as an antichoreic remedy—a credit to which it is certainly entitled, since it undoubtedly cures some cases which have proved rebellious to other treatment.—*British Med. Journ.*

## MEDICAL NEWS.

### DOMESTIC INTELLIGENCE.

*Army Medical Board.*—A Board of Medical Officers, to consist of Surgeons C. A. Finley, C. McDougall, and W. J. Sloan, has been ordered to assemble in New York City on the 1st of May, or as soon thereafter as practicable, for the examination of assistant surgeons for promotion, and of such candidates for appointment as may be invited to present themselves before the Board.

*Medical Graduates 1861.*—We continue our list from p. 58 of our previous No.

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*Medical Society of the State of Pennsylvania.*—The annual meeting of this Society will be held this year at Pittsburgh, commencing on the second Wednesday in June (12th). All the railroad companies, we are informed, have agreed to furnish free return tickets to delegates, on presentation of their

credentials. We trust that there will be a full attendance at this meeting, as an important influence may thereby be exercised in encouraging medical organization in the western portion of our State.

*Jefferson Medical College.*—Dr. Wm. V. KEATING has been elected Professor of Obstetrics in this School, to fill the chair recently vacated by the resignation of Dr. C. D. Meigs. Dr. K. is a well-educated and experienced physician, and will, we feel sure, fill, with honour to himself and credit to the School, the chair to which he has been appointed.

*New York Eye Infirmary.*—We learn from the annual report of the surgeons of this long established and eminently useful institution, that during the year 1860, 4,907 patients were prescribed for, of whom 4,559 laboured under diseases of the eye and 348 diseases of the ear. In addition to the benefits thus conferred directly on the poor afflicted with diseases of these two important organs, clinical teaching is regularly given, and thus students are afforded facilities for becoming acquainted with diseases of the eye and ear and their treatment.

OBITUARY RECORD.—Died, 29th of March, in Davenport, Iowa, Dr. E. J. FOUNTAIN, aged 32. Dr. F.'s death is ascribed to an overdose of chlorate of potassa, taken by him seven days previously. About two drachms of the salt were found in the urine on the first day. At the autopsy there was found inflammation of the alimentary canal, especially the stomach and jejunum; the kidneys were inflamed, enlarged, and obstructed, and contained crystals.

It is well known that Dr. F. has been strenuously advocating the use of large doses of chlorate of potash in phthisis, scrofula, and some other diseases, which he maintained were highly beneficial and entirely devoid of ill effects; and just before his death he published several cases to illustrate these views, and to show that the ill effects observed by some practitioners from large doses of the medicine resulted entirely from the impurity of the article employed. He asserted that since he had used the French preparation he has seen no ill effects from large doses.

## FOREIGN INTELLIGENCE.

*Diphtheria.*—Dr. Greenhow read a casual communication to the Harveian Society (March 7) upon some cases of diphtheria, which had come under his care in a family in Hertfordshire. The importance of the closest scrutiny was urged in a diagnostic point of view, lest this disease should be mistaken for croup. Dr. Greenhow thought that cases of diphtheria were likely to occur again in the same family; indeed, such seemed to have been the case in the family referred to. Dr. Greenhow also stated that the diphtheritic membrane extends down the œsophagus into the stomach, spreading by continuity of surface. Paralysis was also stated to be frequently consequent upon diphtheria, sometimes hemiplegia, most frequently paraplegia; the first of these being accompanied with affections of the voice, sometimes lasting for many months. Chorea might also come on after this disease.

*Complete Absence of the Vagina.*—At a meeting of the Society of Surgery (Paris) M. Verneuil related a case occurring in the practice of Dr. Patry in which, in a girl seventeen years of age, there was an entire absence of the vagina, when the usual general phenomena of menstruation took place. An artificial vagina was established. The patient has been married eight years, and continues to menstruate regularly, but has never been pregnant.—*Brit. Med. Journ.*, Feb. 16, 1861.

*Quackery in Prussia.*—[The correspondent of the *Medical Times and Gazette*, in a letter dated Bonn, Feb. 27, 1861, gives the following account of charlatanism in Prussia.]

"According to my promise, I to-day send you a short account of the professional career of the lately deceased Dr. De Leuw, who in England was honoured with the name of the 'Prussian Oculist.' It is certainly flattering if a countryman acquire fame abroad; but Germany is happily well supplied with physicians and surgeons of far superior talent and acquirements than the one just mentioned possessed, if, indeed, it is possible to draw a parallel between him and scientifically educated medical practitioners. De Leuw was originally 'a surgeon of the second class,' a strange remnant of olden times. As is the case with the

English dressers, these surgeons were men who had not received a liberal education, and did their work by the direction of the physicians, who thought it beneath their dignity to touch a lancet or a knife. Surgery is now at least on the same level with medicine, and has certainly the advantage of not being trammelled and infested by nebulous ideas and theories; but in Germany, as everywhere else, surgery has proceeded from the barber-shops, and has only slowly divested itself of the character of trade. 'Surgeons of the second class' no longer exist in Prussia, where now a thorough surgical and obstetrical proficiency is required of every medical practitioner; and in this respect Prussia is certainly far ahead of many other countries. But, at the time of the great war with France, a virtue was made of necessity, and a great number of men who were only capable of performing the smaller surgical operations, were enrolled as army-surgeons, and also received a license to practise medicine. At the close of the war, in 1815, it would have been unjust to recall the license, and they were thus allowed to continue the practice of medicine, at least in such places where there were no regularly qualified physicians. This was the case with De Leuw, who had been educated at a school of surgery which then existed at Düsseldorf, and at the head of which were Professors Joseph Naegle, a clever oculist, and brother of the famous gynecologist of Heidelberg, and Dr. Reybald. De Leuw practised as army-surgeon during the French war; he afterwards settled in the small village of Graefrath, near Solingen, where he soon acquired a good reputation as oculist.

"It seems that a correct view of the so-called Egyptian ophthalmia, which was then very prevalent among the armies, and had from them spread to the general population, went far to render him favourably known. His only contribution to medical literature is a book on this disease, which was published in 1824, and gives a favourable impression of the practical talent of the author. It certainly shows that he was a good observer; and since in ophthalmic surgery an accurate diagnosis of the disease is more than half the battle won, we cannot wonder that he met with great success in his treatment. How often even at the present day are granulations of the conjunctiva, as the

cause of many cases of inflammation of the cornea, overlooked, and patients are treated for years with all sorts of collyria, before the surgeon is struck by the idea to just turn up the eyelids, where the seat of the disease is to be found. Many oculists owe their reputation to the circumstance that a patient comes to them who has for years been unsuccessfully treated, because no correct diagnosis was made, and who, of course, rapidly improves as soon as the remedies are applied to the proper place. We have also reason to believe that De Leuw in a former period of his life was possessed of no inconsiderable skill as an operator. It is true that he exclusively had recourse to reclinatio; but he certainly practised it with great dexterity. On the other hand, his prescriptions were exceedingly funny. He gave every day a different collyrium, and the strangest combinations of herbs were brought to bear upon the disease. The flowers of *melilotum*, the *summitatis malva*, oak-leaves, the *semen papaveris*, and dozens of others play an important part in his eye-waters. A whole series of spirituous tinctures for washing, and the most curious plasters and ointments were also alternately used; at the same time abominable mixtures, the utility of which cannot possibly be imagined, were prescribed for internal use, and more especially in cases of incipient cataract, the hopes of the patient were kept alive by a fresh mixture every day, until the operation gave the finishing stroke to the disease. Purpose or critical selection are not to be observed in his prescriptions, some of which fill several pages; and evil tongues would have it that the apothecary was a confederate of the doctor. In the meantime the business flourished; in Graefrath, one inn was built after the other, and as every patient had a special attendant given to him, it is easily to be conceived that the prosperity of the place entirely depended upon the 'Wonderful Doctor.' The ruler he was in his manner toward his patients, the more his advice was sought after. A sad fate refused the old man the gratification of his principal wish, viz., that his only son should succeed him in his practice. This young man was well educated, and possessed considerable talent, but dissensions grew up between the two, and at last the son preceded his father to the grave. De Leuw had procured himself a diploma at Giessen in the well known

fashion; and although this was not legally recognized, the Prussian authorities closed their eyes, in consideration of the benefits he had conferred upon the place. A grateful patient in high life—one of our infinitesimal princes—honoured him with the title of Hofrath (Aulic Councillor), and he thus attained the summit of his glory, which, however, for the last twenty years, was entirely limited to foreign countries. The new development of ophthalmic surgery, which has been attended by so highly important practical results, was not at all to the taste of old De Leuw, who never paid any attention to it; we cannot, therefore, think that we have suffered any severe loss by his death. \* \* \*

"We must say that we have always wondered why people came so far to consult a man such as De Leuw, when they could have the advice of men of the stamp of Mr. Bowman, and Mr. Dixon, so much nearer home. But '*omne ignotum pro magnifico*.' It is more probable that the place where De Leuw has resided for so many years will feel his loss, by the absence of wealthy English patients, who will no longer be attracted to it, and for innkeepers, attendants, and the apothecary there, a very gloomy prognosis indeed seems to be justified.

"Dr. De Leuw's career is another proof that in Germany, as well as in all other countries, there is a class of doctors who enjoy a widely-spread reputation, without its being easy to discover why it should be so. Perhaps there is no sphere of human knowledge in which the general public assume to themselves a greater right of having an opinion of their own, than medicine: health and disease are of such immediate personal interest to men that, trusting to their own perceptions of what agrees and disagrees with them, they consider themselves as much or even more competent to judge for themselves than medical men who have made the subject a life-long study. The fact that a thorough insight into morbid processes is only possible to such as have an intimate knowledge of the healthy conditions of the body and its functions, that is to say, of anatomy and physiology, and of those changes which pathological anatomy teaches us do take place in the system, seems still at the present moment to be so foreign, even to many medical men, that we can scarcely find fault with

the public if they do not appreciate scientific medicine, and care little about the way in which they are treated or rather maltreated. They think there must be some remedy, whatever it may be; and if a man confidently asserts that he has a cure for every symptom, he is certain to find many believers, as the symptom is generally considered to be the disease itself. We cannot, therefore, wonder that the most absurd of all systems, viz., homœopathy, has so quickly found a home everywhere. It accommodates itself to public prejudices, nay, it even panders to the erroneous view that the symptom is the disease, and then propounds the theory of infinitesimal dilution which is pathetically repeated at the corner of every street. At the same time we must confess that if we see at the present moment spirit-rapping, table-turning, animal magnetism (practised by 'strong' mediums), carried on with the greatest earnestness in the highest circles of society—in Rhenish Prussia especially, by a beautiful and highly gifted mediocrity—princesses—we cannot wonder if other seemingly less ridiculous quackeries should be easily swallowed by persons in a more humble sphere of life.

"In Bonn, charlatanism is just as rife as it is in Brighton; and if you are blessed with cobblers who make ten thousand pounds a year by plastering and kneading their patients, we, on the other hand, can boast of shepherds and old women who make a scarcely less number of thalers by just as ingenious practices. The nostrums are, of course, always composed of the commonest things; but as they are concocted by the quacks themselves, it is not known what they contain.

"On the Kreutzberg, from the top of which the finest view of the seven mountains and the valley of the Rhine is to be had, there lived recently an old shepherd who had had a most extensive practice for many years. He was consulted in a somewhat anomalous fashion—samples of urine, accompanied with handsome fees, being sent to him for inspection from far and near, and he, in return, sent herbs for the cure of every ill that flesh is heir to. There is also a little spot near Godesberg, where a short time ago little more than a few dung-heaps were to be seen, and now a whole village has sprung into existence, solely in consequence of the remedial powers ascribed to an old woman, called the 'Schweinheimer

Frau' (literally, the woman of the pig's home), who has amassed a nice little fortune by the inspection of urine. Her sons-in-law have built several inns, in which the patients who come to consult the woman are received, and are confirmed in their confidence in the curative powers of the old witch by the wonderful tales of their hosts. If you remember that almost the entire population of the Rhenish provinces of Prussia are Roman Catholics, you will not be astonished that we have also much superstition here. Thus, every year, on the feast-day of the holy Apollonia, crowds of peasants throng to the cathedral of Bonn, to seek relief of the toothache through the intercession of the Saint, the cure of this ailment being her specialty. Then we have the Holy Virgin of Kevlaar, who has been so well described by Heine in one of his best poems, the beauty of which, however, is scarcely to be perceived in the English translation:—

'The mother of God at Kevlaar,  
Her best dress wears to day;  
Full much hath she to accomplish,  
So great the sick folks' array.

'The sick folks with them are bringing,  
As offerings fitting and meet,  
Strange limbs of wax all fashion'd—  
Many waxen hands and feet.

'And he who a wax hand offers,  
Finds cured in his hand the wound;  
And he who a wax foot proffers,  
Straight finds his foot grow sound.

'To Kevlaar went on many crutches,  
Who now on the tight rope skip;  
And many a palsied finger,  
O'er the viol doth merrily slip.'

"She receives, in fact, even at the present day, scores of waxen hearts, arms and legs, from the sick, who believe that by such offerings she will be induced to cure their corresponding ailing members of their bodies; and a roaring trade in waxen limbs is driven there.

"The quacks in this neighbourhood have generally a mysterious way of speaking and acting, and keep in their pay one or more confederates, or 'factotums,' as they are called, whose duty it is to work upon the imagination of the patients by tales of wonderful cures; and who are, therefore, of the greatest importance for the success of their employers. To this class belongs a young oculist at Königswinter, who was formerly a student at this University, and is quite devoid of talent, but has recently created much sensation. His factotum is a

barber; and a barber in this capacity is well worth his keep; for as the Germans do not themselves shave, but are shaved by the barber, and such a person has consequently access to the closets of the highest dignitaries, he is almost always an influential man, and he is also the chief source from whence the strangers in the hotels derive their information of what is going on in the place. The barber in question, is continually talking of a wonderful cure just performed on a Russian Countess, who has come all the way from Tobolsk, in Siberia, where her husband is an exile, to consult Dr. So-and-so; or of a French Marquis, who, after having consulted the most eminent oculists in Paris and London, and was given up by them, has come to Königswinter, seen the doctor, and been cured. The treatment commences with a pair of blue spectacles, which are given to the patient, and in the profits of which the barber is a sharer; secondly, artificial leeches are ordered, which are, of course, much more efficacious than the natural ones, as they are a great deal more expensive; at last, in order to make the process of cure as mysterious as possible, the patient is confined to a dark room for forty hours. As this mode of proceeding is entirely novel, people, of course, consider the doctor a genius.

"It is a curious fact, that almost all our quacks take to small towns and villages, and seldom venture into larger places, such as Bonn and Cologne, where they would soon be put down. Thus one of the chief charlatans in the whole province, a quondam master turner of the name of Baunscheidt, lives in the small village of Enderich, near Bonn. This fellow has constructed an instrument, to which he has given the grand and highly significant name of 'lebenswecker' (life's awakener). With this he performs a sort of acupuncture, and then rubs into the wound thus made a mixture composed of croton-oil and other oils, and which is called by the people gnat's-oil. By this process he cures everything, unless carbuncle should supervene in consequence and kill the patient, which has not unfrequently been the case. However that may be, Baunscheidt does a flourishing business, and his 'lebensweckers' are exported to all parts of the globe. Quite lately a series of advertisements of this new panacea appeared in the *Times* newspaper."—*Med. T. and Gaz.*, March 9, 1861.



**Influence of Pregnancy on Insanity.**—DR. TANNER, in his recent work on the *Signs and Diseases of Pregnancy*, says that in his experience insanity in women is not benefited by becoming pregnant, and that, in two cases under his observation, marriage only aggravated the morbid symptoms.—*British Med. Journ.*, Feb. 23, 1861.

**Causes of Lead colic.**—As instances of the slight causes which may lead to the contamination of the system by lead, two cases are recorded in the *Bulletin Général de Thérapeutique*. In one, the patient was a manufacturer of pewter boxes for marine stores. The other patient was employed at a tea merchant's, in making bags of sheet-lead for holding tea. (*Bul. Gén. de Thé.*, Jan. 15th, 1861.) A number of analogous cases were reported some years ago by Dr. Ioman, in the *Liverpool Medical Journal*.—*Ibid.*

**Aneurism of the Basilar Artery.**—A soldier died suddenly, some months ago, in one of the hospitals of Genoa, from the rupture of an aneurism of the basilar artery. The aneurism was of a fusiform shape, and involved the entire vessel from the junction of the vertebrals to the origin of the posterior cerebrals. A large quantity of clotted blood was found beneath the arachnoid. There was likewise disease of the heart and great vessels.—*Ibid.*, Feb. 9, from *La Liguria Med.*, 1860.

**Needle traversing the Body.**—A Spanish medical journal gives the details of a case where a girl, 14 years of age, swallowed a needle upwards of two inches in length, which some months afterwards escaped at the left groin. During the passage of the needle, the patient suffered from severe gastric derangement, emaciation, and prostration.—*Ibid.*, from *La Espana Med.*, 1860.

**A new Caustic for Toothache.**—The following treatment is recommended by Dr. Calvy, of Toulon, for the neuralgia proceeding from carious teeth. The carious cavity is first to be cleaned out, and then a piece of cotton, steeped in a solution of six grains of acetate of morphia in an ounce of nitric acid, is to be applied to its interior. As soon as the caustic penetrates into the carious tooth, the pain ceases, and the patient is cured. After the application of the caustic, the cavity should be filled with cotton steeped

in the sedative solution of opium, and afterwards permanently plugged.—*Ibid.*, from *Gaz. des Hôpitaux*, Jan. 10, 1861.

**Substitutes for Quinia.**—The Society of Pharmacy of Paris have offered a prize of 6000 francs, to which the Minister of War will add 4000 francs, for the discovery of a substitute possessing equivalent febrifuge properties to quinine, or for the artificial formation of the alkali. Nine essays have been sent in, neither of which has been thought deserving of the prize, which is left open until 1st of July, 1861.—*Ibid.*

**Novel Treatment of Tetanus.**—It is stated in the *Breslau Gazette* that there prevails in the village of Lassen in Prussian Silesia a species of tetanic affection, the prominent symptom of which is a spasmodic closure of the mouth, and which terminates in death on the third or fourth day. The inhabitants, instead of applying to a physician, endeavour to cure the disease by forcing open the mouth with the key of a chapel, wet with holy water.—*Moniteur des Sci. Méd.*, March 14, 1861.

**New Physician Extraordinary to the Queen.**—DR. WM. JENNER, Physician to University College Hospital, and to the Hospital for Sick Children, has been appointed Physician to the Queen in the place of the late lamented Dr. Baly. It is stated that the appointment had been previously offered to Dr. Acland.

**Prohibition of the Use of Copper Cooking Vessels.**—By a decree lately issued by the Prefect of Police, the use of copper vessels for the preparation of all articles intended to be used for food is prohibited in France.—*Moniteur des Sci. Méd. et Pharm.*, Feb. 23, 1861.

**OBITUARY RECORD.**—Died in London, March 18th, 1861, of paralysis, Sir WILLIAM PYM, M. D., K. C. H., aged 84 years. Dr. Pym was for many years connected with the Medical Department of the British Army, was made an Inspector General in 1816; and was the author of an interesting book on yellow fever.

— at Paris, 23d March, M. FERRAS, Inspector General of Asylums for the Insane and of Prisons, aged 75.

— at Strasbourg, recently, M. FORGET, Prof. of Medicine of the Faculty of that city.